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THIS JOURNAL IS MANUFACTURED UNDER WARTIME CONDITIONS IN CONFORMITY WITH ALL GOVERNMENT REGULATIONS CONTROLLING THE USE OF PAPER AND OTHER MATERIALS

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ADMINISTRATIVE ASPECTS OF NEUROPSYCHIATRY IN THE ARMY

BY COL. WILLIAM C. MENNINGER, M.C.*

Under the wise and competent guidance of Colonel Thomas W. Salmon, neuropsychiatry made an enviable record during the First World War. Many lessons were learned. Volume X in The History of the Medical Department excellently sets forth these experiences.

Following this war, as the Army shrank to peacetime size, neuropsychiatry dropped out of the picture and remained out until early 1941 when Lt. Colonel Patrick S. Madigan was called into the Surgeon General's Office to advise regarding neuropsychiatry. He was succeeded by Colonel Roy D. Halloran on 17 August 1942. Colonel Halloran, with the able assistance of Lt. Colonel Malcolm J. Farrell, assumed the responsibility for the development of neuropsychiatry in the Medical Department of the Army. During the following 15 months until Colonel Halloran's death (10 November 1943), many important developments took place, including the appointment of consultants, the publication of a manual on army neuropsychiatry, and the placement of Replacement Training Centers and division psychiatrists.

Immediately following his appointment (1 June 1943), Major General Norman T. Kirk gave far-visioned and aggressive leadership and support to the further development of this field, and was ably assisted by Brigadier General Charles C. Hillman, Chief of Professional Services. The vision and understanding of these men has made possible many other progressive steps.

On 1 January 1944, neuropsychiatry was raised from the position of a Branch of the Medical Practice Division to that of an independent division on a parallel plane with medicine and surgery. The number of medical officers in the division has been increased from three to eight, four of them having been added within the last 6 months.

When the Medical Department instituted a plan for the selection of outstanding civilian physicians to act as consultants, neuropsychiatrists were included. A team, composed of a neuropsychiatrist, a surgeon, and an internist, was placed in the Office of each Service Command Surgeon,

* Director, Neuropsychiatry Consultants Division.

and in each Theater of Operations. The following Service Command Consultants were appointed in the following order: Colonel Franklin G. Ebaugh, M.C., Eighth Service Command, 27 September 1942; Lt. Colonel William C. Menninger, M.C., Fourth Service Command, 24 November 1942 (transferred 10 December 1943); Lt. Colonel Douglas A. Thom, M.C., Second Service Command, 8 April 1943; Major Garland H. Pace, M.C., Seventh Service Command, 6 January 1943 (transferred 25 September 1943); Lt. Colonel Lauren H. Smith, M.C., Ninth Service Command, 23 August 1943; Lt. Colonel Wilfred Bloomberg, M.C., First Service Command, 26 November 1943; Lt. Colonel Clarke H. Barnacle, M.C., Seventh Service Command, 1 December 1943; Lt. Colonel Paul Schroeder, M.C., Fourth Service Command, 7 February 1944; Lt. Colonel Henry W. Brosin, M.C., Third Service Command, 18 February 1944; Colonel William J. Bleckwenn, M.C., Sixth Service Command, 11 July 1944; and Major William H. Dunn, M.C., Fifth Service Command, 25 August 1944.

The overseas consultants have the responsibility for the supervision of all psychiatric problems within their respective theaters and to a considerable degree are autonomous and independent of The Surgeon General's Office.

Lt. Colonel Samuel A. Challman, M.C., was appointed the Neuropsychiatric Consultant for the Southwest Pacific Theater, 10 May 1942; Colonel Lloyd J. Thompson, M.C., was appointed for the European Theater 12 August 1942; Major Frederick R. Hanson, M.C., was appointed to the North African Theater, 5 May 1943; and Lt. Colonel M. Ralph Kaufman, M.C., was appointed to the South Pacific Theater, 27 August 1943. Consultants in other theaters have not as yet been appointed, although consultants have been appointed to various armies.

In addition to these serving as consultants, psychiatrists have been placed in strategic posts throughout the Army. They have served in Induction Centers, and here they have been ably assisted in many instances by civilian psychiatrists. They have been posted in all types of Army hospitals with over 250 beds. About 30 October 1942, they were placed in charge of Consultation Services in Ground Force and Service Force Basic Training Camps. On 9 November 1943, they were placed in each Combat Division. Each Rehabilitation Center, the Army's designation for the training post for minor criminal offenders, has had psychiatrists. The Redistribution Centers, at which men are examined when returned from overseas, have been provided with psychiatrists. The Separation Centers, from which men are discharged, include psychiatrists.

The demand for army psychiatrists has far exceeded the available supply. Furthermore, even well-trained psychiatrists from civilian life needed

assistance in learning the Army methods, particularly the administrative procedures. As a consequence, a School of Military Neuropsychiatry was established under the direction of Colonel William C. Porter, M.C., at Lawson General Hospital on 1 January 1943. Classes, averaging from 20 to 30 medical officers, were given instruction for a period of one month until October 1943, at which time the School was moved to the Mason General Hospital in Brentwood, Long Island, New York. The need for additional psychiatrists led to a lengthening of this course from one to three months, in order that it might provide more extensive training, a change which was made in February 1944 and has continued to the present time. In addition, a three-months' course covering the same subject was given to 40 medical officers at Columbia University and to 30 at New York University. It is anticipated that both of these universities, in addition to the School at Mason, will be utilized in the coming months. Training in psychiatric nursing is provided in several Service Commands.

To further alleviate the shortage of psychiatrists, as well as to bring about more effective psychiatric practice, clinical psychologists were assigned to larger hospitals under an authorization of 1 July 1944. At the same time, Lt. Colonel Morton Seidenfeld was appointed the Chief Psychologist, functioning out of the Adjutant General's Office but with close cooperation with the Division of Neuropsychiatry of The Surgeon General's Office.

On 13 July 1944, social workers were authorized for psychiatric installations. About the same time, on 6 July 1944, the Mental Hygiene Consultation Services were extended to eight additional Army Service Force installations.

All of the psychiatrists in the hospitals in Army Service Forces Training Centers, in the Rehabilitation Centers, are under the direction of Army Service Forces, of which The Surgeon General's Office is a part. The psychiatrists assigned to a division, those in the Ground Forces Replacment Training Centers and those in Evacuation Hospitals are all under the direction of the Army Ground Force Surgeon, and have only an indirect relationship to the Division of Neuropsychiatry in the Surgeon General's Office. The psychiatrists in the Air Forces, headed by Lt. Colonel John Murray, are directly responsible to the Air Surgeon, and also have only an indirect relationship to the Division of Neuropsychiatry in the Surgeon General's Office.

The Division of Neuropsychiatry has had many contacts with various other Divisions in the Army, such as: Personnel, Training, Operations, Nursing, Supply, Judge Advocate, Provost Marshal, Transportation, Morale and Adjutant General.

Through regular Army channels, it has been possible to disseminate a considerable amount of neuropsychiatric information to officers and

particularly to members of the Medical Department. Various changes in regulations have been effected with benefit to the neuropsychiatric patients. In addition to outlines of lectures in Mental Hygiene for officers and enlisted men in all branches of the service, outlines for treatment and reconditioning of neuropsychiatric patients, instructions regarding psychiatry in Induction Centers, descriptions of neurological diagnostic techniques and similar technical information have been published and distributed to the field.

Major support and help has been received from the National Research Council's Committee on Neuropsychiatry and from the Sub-Committee on Psychiatry. In addition, four civilian psychiatrists have been appointed as Consultants to the Secretary of War, three of them representing the American Psychiatric Association, Arthur H. Ruggles, Edward A. Strecker, and Frederick W. Parsons, and the fourth, Doctor Edwin G. Zabriskie, representing the American Neurological Association. These individuals meet periodically with the officers in the Division of Neuropsychiatry to advise with them on policies and practices.

Neuropsychiatry has made progress in both its organization and practice in the Army. Much of the job lies ahead. In order to present the total picture as it exists to date, each of my associates in the Neuropsychiatry Division of The Surgeon General's Office is outlining briefly his special field of activity.

PSYCHIATRY IN TRAINING CENTERS

By LT. COL. MALCOLM J. FARRELL, M.C.*

During the early training period and particularly before the outbreak of hostilities in our present military effort, it became obvious that a special effort would have to be made in order to provide facilities for the prevention and early treatment of mental disturbances in new trainees. Great faith had been placed in the induction screening process. It was hoped that a sufficiently tight screening process would be the answer to the neuropsychiatric problem in the Army which was one of the most difficult problems encountered by the Medical Department in the last war. While induction screening could be counted upon in a large measure to prevent the induction of obvious psychiatric cases and those with weak personalities who might become early casualties, it did nothing toward the prevention of psychiatric casualties within the Army. It is inevitable that even under the most exacting induction examination, many individuals will be missed who could not adapt themselves to military life. The position of the psychiatrist in the Army during the early days of our present military effort made it almost impossible to center his attention on prevention. Most of the psychiatrists were assigned in general and station hospitals where they only came in contact with men who had already broken down and to accomplish the desired results a radical change was necessary not only in the concept of the duties of the psychiatrist but to the type of unit to which he was assigned.

It was necessary therefore to take some of the psychiatrists out of hospitals and put them in the field where they could initiate a plan of preventive psychiatry and where they could treat individuals who were in the first stage of maladjustment. It was evident that the ideal place to accomplish prevention and early treatment was in the replacement training center. At these centers the new soldier is given basic training and the stresses of the Army routine first become evident in emotionally unstable and intellectually inadequate individuals. Even the well integrated personality experiences adjustment difficulties.

In response to certain local demands, mental hygiene clinics had grown up spontaneously in two or three replacement training centers. The success of these units was immediately recognized and plans were made to provide each replacement training center with a mental hygiene unit. In September 1942, 15 replacement training centers were authorized to have such service and in April 1943 this was extended to all 33. Thus, with the aid of clinical psychologists and psychiatric social workers, a

* Deputy Director, Neuropsychiatry Consultants Division.

clinical team was established to engage in the triple function of screening, prevention and treatment.

The general functions of the psychiatrists in these training centers are as follows:

(1) To institute an advisory service, assisted by a qualified psychologist and such other personnel as may be made available, to aid the newly inducted soldier to make a satisfactory adjustment to his military duties.

(2) To aid, by professional methods, individuals who have been brought to the psychiatrist's attention, in order to make full use of their training and capabilities or to recommend reclassification of those who are being trained in a skill beyond their capacities.

(3) To study and recommend remedial measures for those individuals who manifest behavior problems.

(4) To recommend for immediate discharge from the service such men who, because of mental or emotional factors, cannot function adequately or who present a hazard to the other men.

(5) To develop a liaison with line and medical officers for the purpose of instructing and developing a better understanding of the principles of mental hygiene as applied to the military service.

(6) To aid in the morale program of the station by the use of the psychiatrist's specialized training and knowledge.

Individuals are referred to the psychiatrist through the classification officer or dispensary officer by any one of the following: (1) staff sections; (2) school directors; (3) chaplains; (4) company troops or battery commanders; (5) provost marshall. All requests for action of the psychiatrist contain, or are accompanied by, a statement of the reasons for reference.

The psychiatrist recommends disposition of the cases referred to him by any one or a combination of the following methods: (1) Reclassification, where considered advisable; (2) Special programs, corrective in character, cooperatively developed through conference with school directors, company, troop, or battery commanders, staff, sections and others; (3) Psychiatric observation and treatment in a hospital; (4) Admission to hospital with view to discharge on Certificate of Disability for Discharge because of disability (within this category are psychotics, severe psychoneurotics, epileptics); (5) Recommend for disposition by boards of line officers those soldiers with constitutional psychopathy, mental deficiency, chronic alcoholism and drug addiction.

Experience has indicated that the above functions could be performed more effectually if the psychiatrist were separated from the hospital and identified with the training center headquarters so that he could be known by line officers and remain in close contact with the men during their training. In this position he could develop a better understanding of the training problems of the troops and be able to render more effective

service. In addition his patients could be treated on an out-patient basis and hospitalization avoided in many instances. By informal discussions and formal lectures on problems of discipline to line officers, by talks to troops on homesickness and on fear, by writing columns in camp newspapers, by reviewing AWOL and court martial cases and by taking an active interest in morale in its broader sense, the psychiatrist contributed in a large measure in the development of the soldier to the highest standard.

DEVELOPMENTAL TRAINING UNITS (EXPERIMENTAL)

The necessity for conserving manpower led to the study of possible placement within the army structure of currently unuseable personnel. It was apparent that there was a group of soldiers with neuropsychiatric disorders disabled because of their emotional and occupational maladjustment who were believed to be salvageable. Accordingly it was decided to study a group of these individuals using existing training facilities, training personnel and training aides. These groups were studied under control conditions in three replacement training centers. Units were organized under the control of specially qualified line officers, who were guided by psychiatrists.

The trainees were screened initially by a special classification group including psychiatrists, clinical psychologists and trainer personnel and sent for specified training depending on the individual's emotional, physical and occupational suitability. These trainees were to receive instruction fitting them for some military occupation. They were allowed to progress according to individual capability. A minimum of attention was placed on purely military subjects such as firing on the range, hikes and other strenuous activities. These trainees included patients returned from overseas and patients from hospitals in the zone of the interior. In all instances the units were set up as separate battalions directly under the control of the commanding general of the training center. No special designation of the unit was made and the process of training was carried out without any stigma attached to the group. Every effort was made to improve morale and to point out the necessity for the trainees to accept their responsibilities as soldiers.

Thus, an attempt was made to rehabilitate these neuropsychiatric patients outside of the hospital as it is known that hospitalization contributes to the chronicity of their disabilities. It was felt that the units were quite successful. In a special study of those returned to some type of duty, a substantial proportion was found to be performing satisfactory duties within their limitations. As a result of this experience, recommendations were made to continue and expand this program of a valuable means of retraining emotionally unstable individuals who might otherwise be lost for military service.

NEUROLOGY IN THE ARMY

By LT. COL. WILLIAM H. EVERTS, M.C.*

In the Army, neurology and psychiatry have always been united under the single heading of Neuropsychiatry. Under the Neuropsychiatry Branch of The Surgeon General's Office, neurological problems were handled by the various members of the staff as the problems arose, without coordinated direction from any single source. With the advent of the Neuropsychiatry Division of Professional Services in The Surgeon General's Office, a Neurology Branch was created which focused sharply on the organic aspects of neuropsychiatry. An active program was begun. Personnel responsible for clinical neurology in our Army hospitals were carefully reviewed and any neurologists known to be misassigned were restored to neurological duties.

Early this year it became apparent that certain designated hospitals should be set up wherein all overseas medical neurological problems would flow from Ports of Debarkation and also where the more serious or obscure neurological problems within the Zone of the Interior might receive further delineative study by personnel particularly well qualified in clinical neurology and its various diagnostic techniques.

Accordingly, a number of such centers were set up in named General Hospitals strategically located in various parts of the United States. These centers were so coordinated with the Surgical Division that the neurological and neurosurgical centers were located in the same installation so that the two specialties might better collaborate.

The electroencephalograph has been added to the diagnostic armamentarium of the neurologist in all of these centers as well as in a number of other neuropsychiatric departments in Army hospitals. A number of these instruments have also been installed in base area hospitals overseas where they have been useful, especially in study of head injuries. That there might be a standard application of this new technique, the Army standardized on one superior type of 4-channel apparatus. Special courses of instruction have been set up where the neurological Medical Officers are given four weeks of intensive instruction in the interpretation of the electroencephalogram and the artifacts common to this type of examination. Courses of instruction of 12 weeks have also been set up where the Army trains the technicians who will be responsible for the operation of these machines. Many of these technicians were previously skilled radar technicians released by the Signal Corps to the Medical Department for this new type of work. These schools have carried out this assignment in a most excellent fashion.

* Chief, Neurology Branch.

The maintenance of these EEG instruments receives the well coordinated attention of electronic engineers working out of the Supply Service of The Surgeon General's Office.

In an organization so extensive as the Army Medical Corps, uniformity in the application of the more common diagnostic technques is imperative and, accordingly, a technical medical bulletin was published by The Surgeon General's Office which directed the operative technique and interpretation of the electroencephalogram so that a uniform procedure might be followed throughout the Army. A second such bulletin was published dealing with lumbar puncture, manometric studies, pneumoencephalography and cutaneous resistance studies, and there is in preparation a similar bulletin on epilepsy which is anticipated will further clarify management of this disorder as it occurs in the service.

The dermometer, a new and useful instrument in the examination of peripheral nerve injuries is receiving careful attention in these centers and has been sent overseas for study of the fresh injuries as well.

A new neurological examination form has been submitted for use in the Army which is anticipated will not only be a great improvement, but will also serve as a useful guide to the general Medical Officer in doing a neurological examination.

Neurology has been continuously taught in the School of Military Neuropsychiatry and, in addition, at the two schools established at Columbia and New York University Medical School (Bellevue) for the training of the new Medical Officers (recent internes).

Coordination of the continental and overseas neurology is in progress and it is apparent that there will be a natural flow of these problems to the hospitals best equipped to care for them in the shortest possible time. As a result of these various steps, neurology can now be regarded as being abreast of the other specialties and in a position to offer real assistance in diagnosis and management of the sick and wounded problems involving the central and peripheral nervous system.

RECONDITIONING OF NEUROPSYCHIATRIC PATIENTS

By LT. COL. WALTER E. BARTON, M.C.*

The purpose of the Recondtioning Program of the Medical Department of the Army is to accelerate the return to duty of patients, convalescent from disease and injury, or to prepare those rendered unfit for further service for return to civilian life. Through a planned program of physical and educational conditioning and occupational therapy, men will be returned in the best possible state of physical fitness, better informed and oriented, and mentally fit to accept their responsibilities.

Recreational and diversional activities and occupational therapy have been employed for years by psychiatrists in the institutional treatment of nervous or mental disorders. Improved techniques of producing physical fitness and a strong motivation program of education have been effective in promoting the desired state of physical and mental health.

Last fall the Reconditioning Division, in cooperation with the Neuropsychiatry Division of The Surgeon General's Office, undertook to learn if patients with emotional disturbances arising out of military experiences could be returned to duty through the application of a modified reconditioning program. To test this premise, the Mental Hygiene Unit was established as a section of the convalescent facility of the England General Hospital, Atlantic City, New Jersey. The unit was housed in a boardwalk hotel and consisted of a psychiatrist, psychiatric social workers and clinical psychologists, all with broad experience in mental hygiene clinic practice in a Reception Training Center. A military environment was created which simulated a trial of duty. At the same time excellent recreational and entertainment opportunities were made readily available. An important feature of the treatment program was an analysis of each patient's abilities and an effort was made to redirect him into a job he could perform in the Army. Almost without exception, recommendations made were for service within the limits of the continental United States.

From January 1944 through June, a large group of patients was admitted to the Mental Hygiene Unit from hospitals in the Second Service Command (New York, New Jersey).[1] 58% of the admitted patients were from overseas. During the period of study, 70.5% of the patients were returned to duty. A questionnaire was sent to the Commanding Officer of the unit to which the patient was returned and he was invited to evaluate the physical and mental status of the patient and his adjustment to his

* Assistant Director, Reconditioning Consultants Division.

[1] "The Mental Hygiene Unit Approach to Reconditioning Neuropsychiatric Casualties", Major Harry L. Friedman.—To be published.

duty assignment and also to indicate what kind of an assignment the patient had been given. More than 80% were reported performing satisfactorily on duty. Recommendations made by the Mental Hugiene Unit for duty assignment had been followed in 70% of the cases.

It is recongnized that the above study was made upon a selected group of cases. Only those neuropsychiatric patients were sent to the Mental Hygiene Unit that the psychiatrist in the general hospital believed had a reasonable chance of further service. The validity of the Commanding Officer's statement as to satisfactory adjustment of the patient to his duty assignment is also open to some question. Efficiency reports may not give a true picture of the activity of symptoms. Nevertheless, it was felt that results reported in this tentative form were sufficiently meritorious to greatly extend the placement of neuropsychiatric patients in a reconditioning section. Similar assurances came from the experiences of the Camp Swift Station Hospital and from the retraining centers at Camp Lee, Fort Belvoir and Aberdeen Proving Grounds. From 50 to 80% of neuropsychiatric patients in these units were reclaimed for further duty.

On 10 June 1944, instructions were issued in Army Service Force's Circular No. 175 to extend the reconditioning program to the majority of neuropsychiatric patients in Army Service Force hospitals. The objective was to get patients out of the hospital into a military setting as quickly as possible. Patients are sent to the advanced reconditioning section. Here patients are housed in military barracks away from the hospital atmosphere and dressed in duty uniforms. In the familiar military pattern, they find it easier to accept the fact that the psychiatrist believes they are making progress toward recovery. Patients who still have some degree of neurotic incapacity are organized into separate companies with a modified reconditioning program under the direct supervision of the psychiatrist. Later, when the likelihood of return to duty has been established, they may mix with other patient groups in the advanced reconditioning section in the expectancy of return to duty, and lose their identity as neuropsychiatric patients.

A further change in the management of neuropsychiatric patients being returned from overseas is now in operation. Large convalescent facilities have been created in connection with certain designated general hospitals. Convalescent hospitals have also been established. Neuropsychiatric patients, received from overseas, are sent to the First Service Command reconditioning center at Fort Devens, Massachusetts, the Second Service Command Convalescent Facility of the England General Hospital, Atlantic City, New Jersey, the Eighth Service Command Convalescent Facility of the Brooke General Hospital, Fort Sam Houston, Texas and the Welch

Convalescent Hospital, Daytona Beach, Florida. Other centers for neuropsychiatric patients will soon be in operation in other service commands.

Under the new program, neuropsychiatric patients go directly from the debarkation hospital to the receiving division of the convalescent facility or convalescent hospital. Here they are processed as rapidly as possible. The necessary investigative procedures will usually be completed within a week and the patient then begins active participation in the reconditioning program. This avoids prolonged hospitalization with its hazards of fixed symptoms, lowered morale and loss of manpower. A full daily schedule of planned activities is provided. Physical conditioning exercises, games and competitive sports, swimming and hiking are employed to build physical health and vigor. Educational reconditioning is directed toward orientation, motivation and stimulation of interest. It is planned to extend present occupational therapy to provide a wide choice of shop work and activities that will be integrated with the educational program. Group psychotherapy classes will be organized and guided by psychiatrists with the help of psychiatric social workers and clinical psychologists.

It is well to comment at this point that the reconditioning program for neuropsychiatric patients differs markedly from that of medical and surgical patients. In the latter groups, reconditioning constitutes a program for convalescent care after the completion of definitive treatment. In the case of neuropsychiatric patients, however, the reconditioning program constitutes their only treatment. This makes doubly important the close and continued observation of the psychiatrist over individual patients. Counseling service is to be provided in order that the interests of the patient may be surveyed and wise placement and proper assignment may be made to duty he can perform. For the patient who is not to return to duty, the counsellor will insure understanding of his situation and will assist in the planning for his return home and job placement. Lastly, the reconditioning program provides entertainment and recreation, stressing active participation as much as possible.

In summary, it may be said that the new plan of management of neuropsychiatric patients has the following advantages: 1. It provides improved care for an increased number of patients in convalescent hospitals or convalescent facilities with more effective use of the limited number of available trained personnel. 2. It benefits through stimulating group activities. 3. It conserves manpower and returns to duty patients who might otherwise be lost. 4. It releases hospital beds for those who require definitive treatment. 5. It provides more effective rehabilitation for men who otherwise might grow worse under the often inadequate method of handling psychoneuroses when long periods of hospitalization are required for observation and processing.

PSYCHIATRY IN THE ARMY HOSPITAL

By LT. COL. NORMAN Q. BRILL, M.C.*

During the early phases of rapid expansion of the Army, all soldiers who were incapable of performing duty satisfactorily because of neuropsychiatric disorders were admitted to hospitals for evaluation and treatment. Psychiatrists were immediately thrown into a never ending routine of making diagnoses and recommending disposition. There was no preventive psychiatry practiced and out-patient clinics were generally unknown. The volume of work and shortage of personnel gave little opportunity for treatment.

War Department policy, in the light of World War I experience, was to dispose of individuals with neuropsychiatric disorders who had manifested difficulty in adjusting themselves in the Army. Provision was later made for utilizing some of these men on limited service but the rapid accumulation of large numbers of men in this category for whom no assignments could be found led to the discontinuance of the classification "limited service" in July 1943 and it was ordered that those who did not measure up to prescribed minimum standards for induction were to be discharged. This meant practically all those with psychoneuroses, the only exceptions being those who were physically qualified to perform the jobs they were holding and whose retention in the service was specifically desired by their commanding officers. Mass discharges of psychoneurotics resulted and continued until early in November 1943 when a sudden change in War Department policy was announced. The new policy emphasized the need for conserving manpower and the importance of assigning men in positions in which they could render maximum service. Whether or not men met with the physical standards for induction was not to be considered. Men who could render effective service were not to be discharged.

Up until November 1943, enlisted men with "a neuropsychiatric condition of any kind" were disqualified for any overseas service. The new policy provided that only those with mild transient psychoneuroses would be sent overseas.

In December 1943 it was directed in a Circular Letter from the office of The Surgeon General that no man would be separated from the service merely because he had a psychoneurosis or similar psychiatric disorder. Decision as to an individual's potential value to the service was to be made on the basis of the soundness of his personality rather than on the symptoms he presented at the time. This Circular Letter further provided

* Chief, Psychiatry Branch.

that individuals who, after careful study, were believed to be of potential value at full duty in combat zones would be returned to duty and that those capable of duty less arduous than full duty in combat zones would be recommended for such assignment even if a psychoneurotic disorder were present.

Psychiatry made steady progress in the direction of making treatment available outside of hospitals. The establishment of consultation services in training centers, the organization of out-patient clinics in hospitals and finally the assignment of psychiatrists to divisions did much toward lightening the burden of the hospitals by avoiding indiscriminate hospitalization.

In October 1943 a guide on The Early Recognition and Treatment of Neuropsychiatric Conditions in the Combat Zone was distributed to all medical officers. It emphasized the need for early treatment of neuroses incurred in combat and for avoiding indiscriminate evacuation of neuropsychiatric casualties. Experience has shown that large numbers of men can be returned to duty if they are treated promptly.

The critical shortage of manpower in the fall of 1943 necessitated increased attention to the correction of situational neuroses so that men could be salvaged for further duty. The effectiveness of change of assignment to one more suited to individual skills and capacities and correction of disturbing domestic situations through the employment of the Red Cross and other agencies soon was demonstrated.

In April 1944 the first comprehensive directive on the treatment of psychiatric patients in the Army was published. This directive (Technical Bulletin, Medical 28) gave official sanction for the first time to the treatment of psychiatric patients in hospitals in this country and ended the confusion which had existed up until that time about whether or not psychiatric patients were to be treated. The present policy is to regard every case as salvageable until proven otherwise.

There was a gradual recognition of the undesirability of treating psychoneurotics in hospitals. Such handling tended to fix symptoms, to convince men that they were ill and to supply many individuals whose difficulties arose from faulty motivation or lack of adaptability with a face-saving means of avoiding their duties and responsibilities. More widespread use of consultation services and out-patient clinics was encouraged. Furthermore, a recent Army Service Forces directive has provided for the treatment of the majority of psychiatric patients in facilities out of the hospitals (generally in barracks). They will be in uniform rather than in hospital pajamas and will be given a full time program of psychotherapy, physical and educational reconditioning, occupational therapy and recreation. The program will be compulsory but adequate provision will

be made to meet individual interests. Orientation and motivation concerning the war will be stressed in the educational program inasmuch as experience has shown that defective orientation and motivation play an important role in the development of functional disorders. The physical reconditioning program will be graded in accordance with the capacities of the patients. Centers for this "psychiatric reconditioning" are being established to accommodate large numbers of patients so that group psychotherapy can be utilized and economy of personnel effected. Fairly elaborate facilities for physical and educational reconditioning will be provided in these centers.

Certain general hospitals have been designated as centers for the treatment of psychotic patients. All psychiatric patients requiring closed ward care will be transferred to these centers where they will be given the benefit of treatment prior to discharge from the service. Experience has shown that many of the psychoses which develop in the service are transient in character as compared with psychoses in civilian life and it is hoped that many patients will be well enough to return home upon discharge and will not require further institutional care.

The use of shock therapy for treatment of psychoses was authorized in April 1943 and is now being used in many hospitals. In August 1943 occupational therapy departments were established in all named general hospitals. Equipment and supplies are distributed as standard medical department items. Prior to August 1943, the Red Cross had supervised non-prescription occupational therapy activities and it continues to do so in many station hospitals having no occupational therapist assigned.

Mainly through the efforts of the Neuropsychiatry Division of The Surgeon General's Office, psychiatric social workers have been declared "critically needed specialists" and are now being assigned to jobs in psychiatric installations. Much the same has been accomplished with trained psychiatric ward attendants. The Adjutant General's Office is cooperating with The Surgeon General's Office in assigning clinical psychologists to the neuropsychiatric services of the larger hospitals.

Psychiatrists overseas are doing a commendable job in salvaging many men for service. Psychiatric centers have been established in most theaters of operations and psychiatric reconditioning is carried on in an admirable fashion. Psychotherapy under sedation continues to be used very effectively in selected cases and no longer is there indiscriminate evacuation of neuropsychiatric casualties to this country.

Manning Tables provide for the assignment of at least one psychiatrist to all hospitals with 250 beds or more. In most installations neuropsychiatry has been set up as a section of the medical service. The large neuropsychiatric population of some general hospitals, however, has war-

ranted the designation of neuropsychiatric services which are administratively independent of the medical services. An encouraging psychiatric awareness exists in practically all hospitals and close collaboration is maintained between all services. Internists and surgeons have recognized that psychiatrists can be of assistance in cases other than those of psychosis.

While great strides have been made in the treatment of patients with neuropsychiatric disorders, much remains to be done. The success of treatment is frequently hampered by the presence of defective motivation with regard to the war and the problem is therfore a challenge not only to psychiatrists and to the Army but also to the entire nation.

THE CLINICAL PSYCHOLOGICAL PROGRAM OF THE ARMY

By LT. COL. MORTON A. SEIDENFELD, A.G.D.*

Recent months have witnessed the development of a well organized program of clinical psychology in the Army. More than ninety (90) psychologists have already been transferred to clinical duties in medical installations and many more are in the process of being assigned to such duties.

It is planned that the larger station hospitals as well as all named and numbered general hospitals will provide clinical psychological services to include:

a. Aid in the development and administration of counseling for convalescent patients who are expected to return to military duty.

b. Assistance in the preparation of clinical records insofar as they apply to the use and interpretation of special psychological tests required by the chief of the neuropsychiatric section.

c. Aid in studies of special psychological problems relating to classification and retraining of neuropsychiatric casualties.

d. Assistance of medical personnel in determining appropriate military occupational specialties of men ready to return to duty, with particular emphasis on the selection of assignments compatible with the individual's physical and mental status.

e. Performing such other professional and administrative duties in the hospital as will best assist the neuropsychiatrist in the accomplishment of the mission of proper management and disposition of patients.

Administratively this program is decentralized to the nine service commands under which the individual hospitals operate. An office of the Chief Clinical Psychologist has been established in The Adjutant General's Office, and serving as the author's assistant is Captain Jon Eisenson. Through the medium of these officers, liaison is maintained between The Adjutant General's Office and The Surgeon General's Office in all matters pertaining to the clinical psychological program. In a similar manner, the Chief Clinical Psychologist is charged with liaison functions with the medical installations in the field by close contact with service commands and their personnel who are responsible for this activity.

The National Research Council has appointed an Advisory Board on Clinical Psychology consisting of eminent psychiatrists and psychologists: Doctors Arthur Ruggles, Frank Fremont-Smith and Lawrence Kubie as the psychiatric members and Doctors Miles Murphy, Frederic Lyman Wells, Robert Sears and David Rapaport on the psychological side, with Dr. Walter V. Bingham of The Adjutant General's Office serving as Chairman. The Board advises The Adjutant General and his Chief Clinical Psychologist on matters of policy and procedure as applied to the program in medical installations.

A training program is now being planned and will be used to develop the additional personnel needed for this work.

* Chief Clinical Psychologist.

NEUROPSYCHIATRY IN ARMED FORCES INDUCTION STATIONS, REHABILITATION CENTERS, AND COMBAT DIVISIONS

By MAJ. IVAN C. BERLIEN, M.C.*

Neuropsychiatrists have important functions and responsibilities in Induction Stations, Rehabilitation Centers and in Combat Divisions. Although these fields are not directly related, they all are under the direct supervision of the same office in the Division of Neuropsychiatry in The Surgeon General's Office and, for that reason, are presented in this paper.

I. INDUCTION STATIONS

Since November 18, 1940, approximately 14,000,000 men have been examined for the Armed Services at various induction stations. Of this number, 4,250,000 have been rejected, and approximately 35% of these because of neuropsychiatric and educational reasons. Both Army and civilian neuropsychiatrists have engaged in this work. In major communities, civilian psychiatrists have been generous in their assistance. In a considerable number of stations, all of the examinations have been carried out by Armed Forces psychiatrists because of the lack of available civilian help.

The neuropsychiatric examination has been handicapped by various factors: the limitation of time for making an adequate examination, inadequate number of neuropsychiatrists, and the lack of historical information about the man to be examined. Within the last year, two important advances have been made in neuropsychiatric selection. These are the development of the Medical Survey Program by the Selective Service System, and the publication of further instructions on the neuropsychiatric examination in the form of Technical Bulletin Medical No. 33, dated 21 April 1944.

The Medical Survey Program provides the neuropsychiatrist with a longitudinal personality history of the selectee. This provides the examiner with a check against his cross-sectional view of the selectee, and when such essential data is available it enables the psychiatrist to definitely detect and exclude from the service such individuals as psychopaths, enuretics, epileptics and former patients of mental institutions. It further provides evidence in some cases of a stable background in men who may appear tense, anxious or otherwise neurotic when seen briefly at the induction station and thus prevents the loss of desirable men to the Army.

The advent of Techn. Bulletin Medical No. 33 focused attention on the

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fact that men who exhibit isolated neurotic traits are not necessarily neurotic to the extent that they cannot become effective soldiers, a fact learned by experience in the field.

"TB Med 33" further provided that the selectees in whom a positive diagnosis could not be made but who, nevertheless, were not suited to military service should be rejected without labelling them with an unequivocal neuropsychiatric diagnosis. They are, instead, rejected due to psychoneurotic tendencies. Thus, practice at the induction station is brought more nearly into line with scientific practice elsewhere. At the same time, it does not handicap the rejectee in returning to civil occupation.

A further aid in neuropsychiatric selection is a recently developed personality test to be known as "The Neuropsychiatric Screening Adjunct". This device has been developed, as the name suggests, as an aid in focusing attention on to those individuals who by their execution of the test, indicate personality conflicts or defects. Experimental studies and administrative trials of this test suggest that it will be of much assistance to the neuropsychiatrist in his examination of the selectee.

II. REHABILITATION CENTERS AND DISCIPLINARY BARRACKS

Soldiers who have been convicted of military offenses by a general court-martial are sentenced either to a Rehabilitation Center or to the United States Disciplinary Barracks or a branch thereof. The policy of the War Department is not only to provide a modern system of penology for its charges but, further, to afford deserving prisoners an opportunity to restore to duty honorably. (Conviction by a general court-martial carries with it a dishonorable discharge in addition to penal servitude.)

This modern, forward looking system of penology provides for a "Department of Psychiatry and Sociology". This department functions under the supervision of a neuropsychiatrist and is further composed of sociologists who obtain a sociological history of each prisoner and a clinical psychologist who provides a psychological study of each prisoner, including psychometric tests.

The neuropsychiatrist examines every prisoner and embodies his examination, together with the psychological report and sociological studies in a report to a board of officers known as the Board of Psychiatry and Sociology. This board, usually composed of two line officers and a neuropsychiatrist, meets to hear the cases brought before them at regular intervals. Each prisoner is afforded a clemency hearing in his first six months of incarceration and once each year thereafter. The same, or a different board, similarly hears cases to determine whether or not the prisoners are to be placed in the "honor" or "disciplinary" company which is the first step towards restoration to duty. In either case, the boards make rec-

ommendations to the Commandant who may or may not approve their recommendations, but in any case, forwards the recommendations to higher authority.

Thus the psychiatrist plays an important role in the selection of prisoners for restoration. In addition, he treats those prisoners who are in need of psychiatric attention by both group and individual psychotherapeutic methods. In this he is aided by his staff in providing orientation, motivation and education for the prisoners. The number of men successfully restored to duty is impressive and bears witness to the value of modern penology.

Not only does the neuropsychiatrist recommend for restoration those for whom he holds a favorable prognosis, but he also recommends proper disposition of those for whom the prognosis for restoration does not warrant such action.

The incorrigible psychopath is recommended for transfer to the Disciplinary Barracks, the psychotic for discharge and commitment to a mental hospital, and the mental deficient for discharge under provisions of Section VIII of AR 615-360.

III. COMBAT DIVISIONS

Since their appointment in November, 1943, division neuropsychiatrists have proven their worth and have made of their offices one of the most valuable in the Army.

During training the division neuropsychiatrist maintains a constant neuropsychiatric screening process in the division to ensure that men who are unfit because of neurological or psychiatric disorders will not remain. Similarly, he practices mental hygiene or prophylactic psychiatry to keep neuropsychiatric disabilities at a minimum in his divison. This he does in a number of ways, including the utilization of TB Med 12 and 21, which contain material for lectures on personnel adjustment to officers and men.

The Division Neuropsychiatrist also advises the command of the state of morale of the division and cooperates with other officers in programs designed to increase morale. By compiling data on such matters as venereal rate, AWOL rate, neuropsychiatric incidence, etc., he is able to formulate and maintain a "morale index" for the various regiments, battalions or companies of the division which indicate to him the units requiring attention.

His duties include advising other staff officers when called upon. The Division Judge Advocate General frequently requests him to examine men accused of military offenses, and he frequently testifies as an expert witness regarding the mental responsibility of men being tried by courts-martial.

The Division Neuropsychiatrist aids materially in the classification and assignment of men in order to make use of marginally adjusted men or men of limited intelligence or coordination. In some divisions every AWOL case is referred to the Neuropsychiatrist for examination.

The Division Neuropsychiatrist orients, indoctrinates, and supervises the battalion surgeons in neuropsychiatry so that they, in turn, become his front line agents in practicing mental hygiene, detecting and referring incipient cases to him for treatment or disposition.

In combat the Division Neuropsychiatrist, by operating at the clearing station sorts neuropsychiatric casualties, directing treatment of those whom he decides can be returned to combat and the evacuation of those whose disability is severe. He has at his disposal a certain number of beds within the division area for the treatment of those who are regarded as "exhaustion", for whom rapid recovery may be expected with rest and food plus a minimum of psychotherapy.

The Division Neuropsychiatrist must also serve as a safe-guard against the evacuation of those men who are not true or severe neuropsychiatric casualties, but who escape battle because of conscious or near-conscious factors. He must maintain a standard so that morale does not suffer through the evacuation of men who are not suffering true psychiatric or neurological disabilities nor by the retention of non-effectives. This difficult job, according to reports, is being very well done.

MORALE AND PREVENTIVE PSYCHIATRY

By CAPT. JOHN W. APPEL, M.C.* and CAPT. DAVID W. HILGER, M.C.,†

Morale is a concern of psychiatrists because it is very closely related to mental health. It is well established that the number of psychiatric casualties in a military unit depends largely upon the morale of that unit. Loss of manpower from psychiatric disorders, therefore, can be kept at a minimum only by controlling the factors which determine morale. For this reason establishing and maintaining good morale constitutes the chief objective of preventive psychiatry in the Army.

The principle factors which determine morale such as exposure to danger, job satisfaction, supplies and equipment, the quality of leadership, information and punishment are under the direct control of commanding officers and outside the province of the psychiatrist. Indeed, the psychiatrist is not equipped by training or experience to make decisions on these matters. He can function only by making psychiatric knowledge available to those who have the responsibility for solving these problems.

Preventive psychiatry necessarily must be done by psychiatrists who come in direct contact with commanders and with troops. Probably most is accomplished in this direction by the division psychiatrist. One of his chief functions is to advise the command on morale problems, not only during training but also during combat. However, before being assigned to tactical units, virtually all men entering military service spend several months at a training center. Each of these training centers also has a full time psychiatrist at headquarters who has the assignment of preventing psychiatric disorders during the period of adjustment from civilian to Army life. Army, theater and service command psychiatric consultants also spend a good deal of their time dealing with problems of morale and preventive psychiatry. In The Surgeon General's Office a separate branch in the Neuropsychiatry Division, known as the Mental Hygiene Branch, functions exclusively to assist the command in maintaining the mental health of troops. The Chief of this Branch acts as official liaison between The Surgeon General's Office and the Morale Services Division of the War Department (now known as the Information and Education Division). In addition, there is a psychiatrist on duty within the Morale Services Division itself.

There are three general ways in which psychiatrists are active in preventive psychiatry: (1) educational; (2) motivational; (3) control of environmental stress.

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By *education* is meant what is usually thought of as mental hygiene and actually amounts to the attempt to teach military personnel what has been learned about human nature from the study of mental disease. The premise is that this knowledge can be used by individuals for the maintenance of their own mental health and by commanders in their problems of leadership and morale.

A course of six lectures on mental health is given to all officers in the Army as a required part of their training. These cover the principles of personal adjustment, personality structure, motivation, specific stress factors, signs and symptoms of breakdowns, and measures to maintain the mental health of the group. A similar course of three lectures is also given to all enlisted men. These cover the subjects: personal adjustment problems, fear, resentment, the bodily effect of emotions and a healthy viewpoint toward being in the service. Outlines for these lectures were prepared in The Surgeon General's Office and distributed to all medical officers, as well as the psychiatrists who actually conduct the lectures.

The most effective education, however, is being accomplished by division and training center psychiatrists in personal discussion and informal conferences with commanders. Here the psychiatric viewpoint is brought to bear on problems connected with specific cases of maladjustment, faulty motivation, defective personality structure, misbehavior, etc. In most of the training centers and many of the divisions the psychiatrists meet regularly with commanding officers and noncommissioned officers to discuss various problems of leadership, morale, discipline and mental health.

Articles by psychiatrists on mental hygiene, control of fear, adjustment problems, the cause of nervous breakdowns, etc., have appeared regularly in camp newspapers, War Department pamphlets and periodicals, etc. *Yank Magazine* and *The Infantry Journal*, which have Army-wide distribution, have carried articles done in collaboration with psychiatrists on these subjects. In certain training centers regular bulletins written by the psychiatrists are sent to a cadre of key noncommissioned offiers in each unit. Even radio broadcasts have been used.

Another approach to the problem of prevention is the attempt to increase the soldier's *motivation* toward fighting the war, to bring home to him the degree to which he and his family were threatened by the enemy and to answer his questions about the home front. The official Army agency assigned to this project is the Information and Education Division of the War Department. This Division produces motion pictures, such as the "Why We Fight" films, news reels, radio programs, posters, pamphlets and runs the system of regular group discussion among troops throughout the Army known as the "Orientation Hour". In addition to the

Washington headquarters, each regiment or its equivalent in the field throughout the Army has in it a representative of this organization known as the orientation officer. Division and training center psychiatrists are beginning to act as advisors to these orientation officers both in the selection of informational material presented to troops and in conducting the orientation group discussion programs. In Washington, recommendations made by the Neuropsychiatry Division of The Surgeon General's Office to the Information and Education Division have been adopted which involve major policy in the dissemination of information to troops. The Neuropsychiatry Division has collaborated or acted as advisor in the production of films, radio programs, posters and pamphlets designed to induce healthy attitudes in troops. Program source material is gathered from the Office of War Information, the Federal Communications Commission, the Department of Justice and similar other agencies for this purpose. In addition, the liaison acts as a channel through which reports and suggestions concerning morale, received from psychiatrists throughout the Army, are passed on to the Information and Education Division.

The third approach to the problem is through the *control of environmental stress* factors. The division and training center psychiatrists search constantly for the situational factors which are precipitating psychiatric disorders and recommend to the command measures necessary to alleviate or remove these factors. They survey training programs from a psychiatric viewpoint, advise concerning the training schedules, the method of conditioning troops to battle situations and adjustment to extremes of climate, foreign social customs, and so on. They pay close attention to such matters as the furlough policy and the handling of AWOL cases. Collaborating with personnel placement officers, they seek to prevent many psychiatric disorders by bringing a medical (psychiatric) viewpoint to bear on job assignment problems. In combat psychiatrists perform a particularly vital function by preventing cowards, goldbricks and malingerers from using the honorable medical channel as an escape from combat. Psychiatrists work closely with other agencies important to the mental health of troops—the chaplain, the Red Cross and Special Service or recreation and athletic officers. Finally, in Washington there is increasingly close relationship on matters of Army policy affecting mental health of troops with War Department Staff divisions: Personnel, Training, Judge Advocate General, Public Relations, and other departments.

MILITARY PSYCHIATRIC SOCIAL WORK

By LT. COL. MALCOLM J. FARRELL, M.C., and MRS. ELIZABETH H. ROSS*

The use of Military Psychiatric Social Workers was initiated during this war. Since the assignment of Military Psychiatric Social Workers and the definition of their responsibilities are now in the process of development, any statement about the working relation with, and the service to, psychiatry must be viewed as an interim report.

Classification of enlisted social workers qualified to serve in conjunction with psychiatric activities has been well under way for the past year. At least thirty enlisted men were at work in the NP sections of hospitals, in Consultation Services, or in mental hygiene units prior to the time that civilian social work was listed as a civilian occupation for classification purposes. At least one clinical unit had developed its own standards of civilian training, military job description, service and lines of administration. Reports from these earlier, somewhat spontaneous, expressions of the interest of individual military psychiatrists in the specialized services of case workers were among the several stimuli that led toward an authorized use of social workers in neuropsychiatric units.

The standards of "graduate work with a degree in social work granted by a recognized school of social work" or "at least two years of supervised experience in a public or private agency" were based on an estimate of the maximum military personnel appropriate for social service in a psychiatric unit. They represent a recognized difference from the accepted civilian standards for such positions, and provide for wide latitude in civilian job discipline, information and technical capacity.

As the psychiatric services expanded, as concepts of treatment were formulated and as the military purposes of psychiatry in relation to morale and to full manpower utilization were further defined, the need increased to locate and use all available personnel who could qualify as Military Psychiatric Social Workers. The result of Memo No. W-615-44, paragraph 5, 29 May 1944, subject "Critically Needed Specialists", was to free an appreciable number of qualified men for assignments to neuropsychiatric settings.

The WAC established a requisition for psychiatric social workers, paralleling in civilian background and military assignment the male counterpart. At the same time a new position, and one only open to a member of the WAC, was set up—that of "Psychiatric Assistant." The duties of that position carry with it a recognition of the value to psychiatry of able administrative aid and, by implication, the recognition that the trained social

* Secretary, American Association of Psychiatric Social Workers.

case workers are needed for assignments requiring more skill in individual relations, in judgment and evaluation, and in direct service to disturbed or mentally ill soldiers.

Steps toward locating and reassigning available qualified soldiers were speeded up and furthered through W.D.Circular No. 295, paragraph 5, (13 July 1944). That circular added to the only previous official job description; it also specified that "psychiatric social workers are essential to the proper functioning of the consultation service in training centers, as assistants to Neuropsychiatrists in the neuropsychiatric sections of hospitals and hospital annexes in the zone of the interior". Official communications about consultation centers in ASF Training Centers (ASF Circular No. 208, 6 July 1944) and about AGF and ASF Redistribution Centers (WD Circular No. 303, 17 July 1944) and about the Reconditioning Program for Neuropsychiatric Patients (T.B. Med 80, 3 August 1944) all have advised the use of military psychiatric social workers and in the latter instance extended the description of their possible functions within the mission of the Reconditioning Program.

Military Psychiatric Social Workers are now assigned to mental hygiene units; to the neuropsychiatric sections of hospitals; to outpatient units attached to hospitals, to reconditioning, and to convalescent facilities. A scattered few are working in conjunction with division psychiatrists or in rehabilitation centers. The Army Air Forces have absorbed an appreciable number of their own personnel, particularly in the early establishment and recent expansion of clinical services for men in training and for excombat soldiers.

It is too soon to learn the effect in practice of some of the recent directives relating to psychiatric social work services in military installations. Further steps may be needed to assure an integrated well-staffed service. But there is a growing body of knowledge based on experience coming from these psychiatric units.

To be a good social worker one must be a good soldier; the case work helping process must be firmly rooted in and held to military purpose or it will float in a semipersonal, falsely individual vacuum. Army administrative procedure and services, military regulations and traditions, the purposes and policies of the individual neuropsychiatric services comprise the external framework, shifting as it is, within which social case work treatment can be established.

Military Psychiatric Social Workers have come to recognize positive values in the restrictions inherent in military life for the benefit of the patients with whom they work. They find that those very restrictions can be aids in helping troubled or disturbed soldiers to take hold of their individual difficulties in relation to the Army. They also can be aids in

helping to determine the facts and feelings that are decisive, for instance, for arriving at psychiatric judgment about possible assignment to a reconditioning program.

During the past months, accumulated experience suggests that it is possible to describe a sliding scale in the competence of psychiatric social workers which appears related in large part to differences in civilian experience and training. Differentiated assignments are developing in some units; the job expectation of a soldier who qualifies as a psychiatric social worker on the basis of experience only may be markedly different from the expectation of another who was graduated from a psychiatric social work curriculum and had several years of civilian professional experience. The first man might be assigned to obtain initial routine social histories. The second might—through a series of interviews—work directly with a patient on specific aspects of his military difficulties. He would then submit a report, with recommendations, to the psychiatrist about the extent of the man's apparent readiness to accept his share of the responsibility for whatever next step is appropriate within the realities of Army life. In the first instance, the psychiatric social worker assists psychiatry through the preparation and organization of essential social, military and personal information, as one of the preliminaries to formal diagnosis. In the second instance, the psychiatric social worker assists psychiatry in another of its responsibilities—that of determining through a defined, purposeful, casework relationship, the flexibility, strengths and drives of patients as such factors contribute to psychiatric recommendations for disposition.

Much progress has been made in the utilization of the profession of Psychiatric Social Work in the Army. Individually and collectively these workers have performed an excellent service to psychiatry and to psychiatric casualities.

TREATMENT PROGRAM FOR PSYCHIATRIC PATIENTS IN STATION AND GENERAL HOSPITALS*

1. INTRODUCTION

The acute needs for manpower make it imperative that every treatment method available in station and general hospitals for neuropsychiatric patients be utilized to the maximum. The aim is to salvage every possible soldier for further duty. Those patients in whom there is no hope for salvage should be recommended for discharge.

a. An erroneous attitude prevails that neuropsychiatric patients should not be treated, perhaps because of misinterpretation of previous directives. In too many hospitals, neuropsychiatry is merely a matter of diagnosis and disposition. This must be corrected. The soldier receives the best of medical and surgical treatment, and all neuropsychiatric patients should be given the benefit not only of treatment but of the most scientific methods available. A high percentage of psychoneurotic patients can be salvaged, if treated, and the possibility of their salvage can be determined only by treatment. Only in very exceptional cases can an individual with a psychotic reaction be returned to duty, although many acute reactions can be greatly benefited by prompt individualized therapy. It is therefore desirable that all neuropsychiatric patients be given the benefit of treatment.

b. There is a tendency to misuse the diagnostic term "psychoneurosis." On the other hand, under sufficient stress of a specific type, any individual may develop a psychoneurotic disorder. Consequently, the presence of psychoneurotic symptoms may indicate an extremely difficult situation rather than a "weak" individual.

c. A widespread attitude prevails on neuropsychiatric wards that admission to such wards is tantamount to discharge. This attitude spreads, with infectious virulence, to new patients. Effective steps must be taken by medical officers and all ward personnel to reverse this attitude through individual and group contacts and segregation.

d. Certain general hospitals have been designated for the treatment of psychotic patients, and convalescent (reconditioning) facilities are being established for the treatment of open-ward patients who do not require intensive individual therapy and who give indication of being salvageable for further military duty. The fact that patients may be transferred to such installations should not preclude their receiving treatment while awaiting such transfer.

*Permission to reprint this War Department Technical Bulletin, TB MED 84 was courteously granted by Surgeon General Norman T. Kirk. It was prepared by the Neuropsychiatry Division and distributed to all medical officers in the Army.

2. PHYSICAL ARRANGEMENTS

a. Psychotic and psychoneurotic patients should not be housed in the same ward, except in those occasional instances where active suicidal trends may be present in a psychoneurotic patient. Individuals with constitutional psychopathic states may, in some instances, require closed-ward care.

b. Prisoners, unless neuropsychiatric cases themselves, are not to be housed with neuropsychiatric patients, and in no instance is the guard on a neuropsychiatric ward to be armed with a firearm.

c. So far as possible, psychoneurotic patients will be housed in unlocked open (W-1 or W-2 type) wards. If conservation of space demands that a W-8 ward be used for psychoneurotic patients, the doors will be left open and such reasonable changes effected as to make the ward an "open" ward.

d. So far as manpower and facilities permit, all patients in whom psychoneurotic symptoms are the chief incapacitating features of their illness will be transferred from other sections (orthopedic, cardiovascular, gastrointestinal, etc.) to the neuropsychiatric section.

e. Depending upon the number of patients and wards available, all open neuropsychiatric wards, with the exception of one for acute cases and new admissions, might be located in military barracks, with an attempt to divorce the patients from a "hospital atmosphere." The patients in such wards should be dressed in uniform or fatigue clothes, and required to do their own police work, take care of the ward, their own beds and property, and care for themselves.

3. PERSONNEL

No additional personnel beyond the normal allotment of ward attendants are necessary to carry out the treatment program outlined below. The following suggestions regarding the utilization of personnel should be carried out:

a. (1) Obtain the "permanent" assignment of as many nurses as possible with neuropsychiatric nursing training and/or experience to the neuropsychiatric section, to the end that—

a) The most effective use be made of the nurse's abilities and personality in treatment.

b) Such training as may be further provided will be of direct benefit to the neuropsychiatric patients.

c) The assistance the nurse may give in the treatment program will not be cut short through unnecessary transfer to duty on other wards.

(2) Nurses' aides, under the supervision of the nurse, can be of help in the treatment program.

b. Exercise care in the selection of ward attendants to the end that—

(1) Neuropsychiatric patients be under the supervision of intelligent and emotionally stable individuals capable of contributing to their effective therapeutic management.

(2) Individuals with special skills in sports, crafts, games, and music, especially those capable of leadership in such activities, be utilized to the fullest extent.

(3) Such training as may be given each ward attendant may be of continued benefit in the care of neuropsychiatric patients.

c. In general hospitals, *occupational therapists* are authorized (S. G. O. Circular Letter No. 149, 12 August 1943). When an occupational therapist is available, she should direct all craft activities.

d. Psychiatric social workers and psychiatric assistants are being recruited by the W. A. C. and may be obtained upon requisition through the service command to The Surgeon General's Office. They, together with the Red Cross and enlisted psychiatric social workers (SSN 263) who may be available, can render much assistance in both administrative work and the therapy program.

e. Enlist as much aid from the Red Cross as possible (AR 850-75). Its social service provides assistance to patients having situational or environmental problems, and aids patients to be discharged under section II, AR 615-360, AR 615-368, and AR 615-369. Recreation workers especially can be of major help in the development of an activity program. These workers are not therapists and must be given close supervision by the neuropsychiatrist. Neither these nor other volunteer workers should be expected to recruit patients for classes or activities, nor can they assume responsibility for their attendance.

f. Gray Ladies, under the supervision of the Red Cross, can be of much help as instructors and can assist in the recreation program and provide individual attention.

g. Enlist the part-time or occasional help of other medical, dental, and medical administrative officers and nurses in the leadership of special classes or group activities in their particular hobbies or interests (chess, photography, aviation, art, etc.).

h. The orientation officer may be of great help in presenting indoctrination and orientation material. Special speakers, entertainers, and outside (civilian) instructors may be obtained through and under the supervision of the Red Cross.

i. Special instruction will be given to all personnel working with neuropsychiatric patients. This instruction will be given by the chief of service, presenting special features which pertain to individual patient management.

4. EQUIPMENT

In general hospitals, full utilization of the gymnasium and the occupational therapy shop should be made. In station hospitals, if no separate space is available, a craft workshop can be established on the porch or dayroom of a ward. Every ward or group of patients (including psychotic) should have an adequate outdoor recreation area, sufficiently large to permit active group games. An area for vegetable or flower gardening is desirable. Authorization for the requisition of occupational therapy supplies is set forth in S. G. O. Circular Letter No. 149, 12 August 1943, modified by S. G. O. Circular Letter No. 203, 10 December 1943, which, until such time as a sufficient number of qualified occupational therapists are available, is limited to named general hospitals. The Red Cross organization generously supplies a wide variety of craft and recreation equipment in all hospitals. Regulations authorize the purchase of recreational supplies and library books from hospital funds. The use of hospital funds to supplement the activities of supply services in contributing to the comfort, pleasure, contentment, and the mental and physical improvement of the patients is permissible. War Department Memorandum No. W210-8-43, 4 May 1943, directs that appropriate action will be taken for establishing libraries and supplying recreational materials and periodicals for use by patients in station hospitals within the limits of available hospital funds. Use of the funds is directed by The Surgeon General in S. G. O. Circular Letter No. 120, 8 July 1943.

5. TREATMENT METHODS

a. Program.

(1) Success in the treatment of neuropsychiatric patients will depend upon the utilization of all available appropriate methods. It is essential in all cases—

(*a*) That the patient develop confidence in the physician (transference) and his skill, knowledge, and personal interest.

(*b*) That utilization be made of this confidence by the physician in giving insight to the patient regarding his illness and his opportunity to serve in the armed forces.

(*c*) That constructive activity (sublimation) be substituted for symptoms.

(2) As much of the activity program as possible should be carried out on, or adjacent to, the neuropsychiatric wards. This does not preclude utilization of the entertainment facilities provided in the hospital recreation hall by the Red Cross for all patients.

b. Psychotherapy. Every neuropsychiatric patient should have psycho-

therapy. In a limited number of cases in which much benefit may be expected in a few sessions, individual psychotherapy is justified despite limitations of manpower and time. Unfortunately, these limitations do not permit the universal application of individual therapy. On the other hand, where the neuropsychiatrist is capable of it, group psychotherapy should be given at regular appointments, at least 3 hours a week. Two methods of approach may be used: the lecture-discussion or the question-answer.

(1) In the lecture-discussion method, the neuropsychiatrist presents, in a series of talks, such subjects as orientation to the hospital, orientation to war issues and the importance of personal participation, types of nervousness, causes of nervousness, body-mind relations, the role of dependency, insecurity and inferiority, such environmental factors as authority and regimentation, and, finally, misconceptions regarding mental ill health. In all presentations, free use of illustrative instances should be made, followed by free discussion.

(2) The question-answer method is based upon anonymous questions placed in an easily accessible question box. The neuropsychiatrist answers the questions to the group, again encouraging discussion.

c. Sedation combined with psychotherapy. This treatment is indicated in acute fear reactions, conversion hysteria, fugue, and amnesic states. It is contraindicated in hypotension and severe cardiovascular disease. Most effective drugs are sodium amytal 0.3 to 0.6 gram orally, or a somewhat smaller dosage when administered intravenously, and pentothal sodium 0.25 to 0.8 gram intravenously. Other quick-acting barbiturate derivatives may be used. Morphine is *not* effective and will *not* be used. When used intravenously, the above-named drugs are injected in the antecubital vein at the rate of 0.1 gram per minute, during which time the patient (reclining in a darkened room) is told to count backward from the number 100. Shortly after the counting becomes confused and before actual sleep is produced, the injection is discontinued. Some patients will spontaneously begin to talk; in others the neuropsychiatrist will need to stimulate the verbal response by questions or to create the situation desired by describing it (e. g., the repressed memory of the battle scene) to the patient. The therapist remains an observer unless the situation requires him to play an active role, since some patients may show considerable motor activity. Others may require reassurance regarding anxiety, fear, or guilt, and still others require authoritative suggestion to overcome conversion symptoms. An effective activity program should keep the average patient occupied most of his waking hours.

d. Occupational-recreational-educational activity program.

(1) This program should include opportunities in these fields for both psychotic and psychoneurotic patients. To be effective, the program

must be carefully planned, *prescribed by the medical officer*, and frequently checked for efficiency and suitability. It should aim—

(*a*) To provide outlets for the patient's interest, time, and energy.

(*b*) To substitute activities for the patient's inactivity.

(*c*) To initiate all constructive efforts possible toward rehabilitation of the man, regardless of his eventual disposition.

(2) To develop a well-rounded program requires the assistance and talents of all medical officers on the section, as well as those of the nurses, the occupational therapists, the ward attendants, the Red Cross recreational and social workers, educational reconditioning officers, and as much additional part-time help from other hospital personnel as can be obtained. The first step in the organization of such a program is the development of a "faculty," namely, the potential leadership and teachers for various crafts, skills, hobbies, games, and musical interests. Following such a survey, the chief of the section can determine the activities to be included in the program. These activities should then be scheduled at definite hours and the program for a week outlined in advance. The physicians will prescribe specific activities on the schedule for each patient on the basis of the patient's clinical picture, his capabilities, and his needs. The following types of activities are suggested:

(*a*) *Military activities.* For the majority of psychoneurotic and convalescent psychotic patients, short marches, calisthenics, and certain military classwork sessions should be made a part of each day's program.

(*b*) *Athletics and games.* These include both indoor and outdoor activities. Provide games, competive and noncompetitive, for both individual and group opportunities. The wider the variety, the more effective the program will be. Tournaments stimulate interest. A limited amount of passive recreation (entertainment) is indicated.

(*c*) *Occupational therapy.* In general hospitals, occupational therapists are available and the majority of patients should have at least 2 hours daily in this activity. In station hospitals, occupational therapy cannot as yet be provided, but, until occupational therapists are assigned, assistance from the Red Cross recreation workers can be obtained in the form of hobby guidance, which includes a wide variety of diversional craft activities. So far as possible, the occupational activity should be utilitarian, definitely masculine for all male patients, and of interest to the patient. The program should include as wide a choice of activity as possible. Industrial activities may be indicated, such as the repair of hospital furniture, upholstering, painting, rug making, etc.

(*d*) *Arts.* Individual and group activity in sketching, painting, drawing, soap carving, plaster-of-paris carving, and clay modeling.

(*e*) *Music.* Individual and group activities in singing, recordings, orchestra, composing, music appreciation, and rhythm bands.

(*f*) *Dramatics.* To be used in impromptu form (psychodrama of Moreno) as group psychotherapy. If talent is available, the use of short skits, musical numbers, and pantomime.

(*g*) *Education.* Of special importance would be classes of value to the military service, such as signaling, radio work, simple bookkeeping, first aid, typing, and shorthand. For a number of patients, simple classes in arithmetic, reading, and geography are of much value. Special classes in foreign languages, current affairs, and recreational subjects, such as chess and contract bridge, may have much appeal and be of special benefit to certain members of the group. For source of materials and other suggestions, see appendixes A and B of S. G. O. Circular Letter No. 168, 21 September 1943. Particular attention should be devoted to the establishment of an orientation-motivation program. Orientation films are available for this purpose, and group discussions on current events and topics of general interest related to the war have been found to be helpful and stimulating. Every man who returns to duty should be constantly reminded that he is a soldier, the reasons why we fight, and the reasons why he must fight. Personalize the war for the patient in every possible way, since strong motivation produces better mental hygiene. U. S. A. F. I. Catalog, Second Edition, and section VI, War Department Circular No. 68, 1944, outlines methods of procuring educational materials from U. S. A. F. I. or its branches for individual or class instruction. Copies of the booklet "It's Fun to Learn," which describes educational opportunities under the U. S. A. F. I. plan for hospital patients, are available for distribution to all patients.

(*h*) *Common interest groups.* In any large service it is possible to further specialized interests which will attract and be of benefit to a number of patients. The interests may be presented as classes or merely as group activity and include such fields as radio, model building, photography, fly tying, stamp or coin collecting, sign painting, etc.

(*i*) *Outdoor constructive activity.* Assignment to the care of lawns; development of victory or flower gardens; recreational equipment, such as tennis, badminton, and shuffleboard courts; and walk construction.

e. Shock therapy. Convulsive and subconvulsive shock (insulin, metrazol, and electric) therapy is an accepted form of treatment for selected cases of

psychoses. It is not to be used for psychoneuroses. The use of shock therapy will be governed by the following factors:

(1) This treatment will be given ordinarily only in those hospitals specially designated for the care and treatment of closed-ward psychiatric patients. Other hospitals may employ shock therapy upon the approval of The Surgeon General or, in oversea theaters, upon the approval of the theater surgeon.

(2) The treatment will be given only by or under the direct supervision of a qualified neuropsychiatrist experienced in the form of treatment used, whose qualifications will be approved by the commanding officer of the hospital.

(3) Indications for the use of shock therapy will include psychoses believed to have a poor prognosis without shock therapy, severe affective psychoses, and acutely agitated (psychotic) states.

(4) A complete recorded physical examination will be made to preclude contraindications. This will ordinarily include an electrocardiogram and, except in the case of insulin, a roentgenogram of the spine. When the patient is so disturbed that the electrocardiogram and the roentgenogram cannot be made, a cardiac and orthopedic consultation will suffice until such time as these special examinations can be made.

(5) All precautions to prevent complications will be observed.

(6) All cases for whom shock therapy is proposed by the ward officer will be carefully reviewed by the chief of the neuropsychiatric section, who will approve or disapprove the proposed treatment.

(7) A carefully prepared running record of the treatment will be made a part of the clinical record. The number of shock treatments given any particular patient will be determined by the response of the patient. No patient will be given a single series of more than 12 shocks.

(8) A complete report of any complications will be forwarded immediately, through channels, to the Office of The Surgeon General

f. Hydrotheraphy. The full utilization of prolonged imersion tubs and cold wet sheet packs is indicated in all installations where such equipment is available. The use of these methods as sedative measures is preferable to drug sedation in manic states and in schizophrenic excitement. Due care must be exercised in the prevention of accidents and in close observation of the patient's physical condition throughout the treatment.

g. Drug therapy. Except for symptomatic measures (sedation, tonics, laxatives, etc.) there are few drugs of special value for most psychiatric patients. The appropriate use of vitamins, benzedrine, and endocrine preparations is directed.

h. Ward personnel management. The most important single factor in the treatment of neuropsychiatric patients is the group of personalities (the

ward personnel) with whom they come in contact in the direction of their hospital care. This ward personnel (nurses, ward attendants, social workers, and occupational therapists) is the most potent "medicine" the patient receives, and the attitudes and techniques of this group can produce unlimited benefit or irreversible damage for the patient. The adequacy of their understanding, approaches, techniques, and individual patient management will be directly proportional to the amount and type of training provided for them by the neuropsychiatrist. Under no circumstances should a neuropsychiatric patient be treated with discourtesy or be the object of fun-making. Physically rough treatment on the part of an attendant should call for prompt disciplinary action. Nurses and enlisted personnel should be directed to use their initiative in judiciously stimulating patients to take an interest in some type of activity. Some patients work or play better alone, while others will occupy themselves in an activity with a small group. It is poor supervision which permits ward men to be idle when patients are sitting about with nothing to occupy their time. It is important that most of the patient's waking hours be occupied with some activity, even though it may be of a simple nature.

i. Relation to reconditioning program. Section IV, A. S. F. Circular No. 175, 10 June, 1944, directs that any patient who has even a remote chance for salvage for additional military service will be given a trial in reconditioning and that the reconditioning program will be extended in all Army Service Forces hospitals to include the majority of neuropsychiatric patients. Plans for such a program provide for the establishment of elaborate educational, recreational, and occupational therapy facilities. Since it would be impractical to establish programs in most hospitals, where the number of psychiatric patients who would be eligible for reconditioning would be limited, it is expected that the greater part of neuropsychiatric reconditioning will be done in centers which have been designated for this purpose. For the time being, however, except where it has been otherwise directed the therapy program should be coordinated with the reconditioning program in all hospitals, especially in the utilization of special instructors and physical and educational reconditioning facilities.

j. Transient psychoses. Experience has shown that many psychoses developing in the service are short-lived, and it has not been uncommon for patients to arrive at Veterans' administration hospitals recovered or in a state of remission. When a psychotic patient appears to be improving rapidly, treatment should be intensified with the expectation that recovery can be effected prior to discharge from the service, when discharge is contemplated.

k. Treatment on an out-patient basis. Frequently Army hospitals have found that out-patient clinics make possible a more efficient handling of

neuropsychiatric problems arising on a post. The time of neuropsychiatrists has been conserved and, in many instances, hospitalization has been prevented. Many cases of psychoneurosis and other minor mental disturbances can be effectively treated while patients remain with their units and admission to hospital is reserved for problematic and severe cases. Thus the number of occupied hospital beds can be kept at a minimum. Many cases requiring admission to hospitals for investigation only can be returned to duty and treated as out-patients.

l. Discharge.

(1) At the time of discharge of a psychoneurotic patient, the neuropsychiatrist has a final therapeutic responsibility. A soldier need not be told his diagnosis, but it is essential that the neuropsychiatrist patiently and painstakingly explain the nature of the illness and what the patient should and can do about it after discharge. Every effort should be made to aid the patient in his plans to return to civilian life, enlisting the assistance of the social workers of the Red Cross sufficiently early so that they may, if necessary, communicate with his home.

(2) A separation subsection of the classification section established in The Adjutant General's Office has been assigned the responsibility of supplying each enlisted person separated from the service with a record of his civilian and military experience and training, including the proper application of his military experience to civilian pursuits. It is anticipated that this record will be of value to persons being discharged in relocating themselves in civilian jobs or training programs for eventual job placement. Vocational and educational guidance will also be supplied who desire it.

(3) If further treatment may be indicated, give references to competent civilian physicians or clinics, and explain that the family physician may request a medical report from the commanding officer (par. 2*b* (5), AR 50–590). The neuropsychiatrist should challenge the soldier with his opportunity as a civilian to aid in the war effort.

By order of the Secretary of War:

G. C. MARSHALL,
Chief of Staff.

Official: J. A. ULIO
Major General,
The Adjutant General.

Editorial Notice

The Menninger Foundation, a non-profit organization for the furtherance of psychiatric research, education and treatment, takes over the publication of the Bulletin of the Menninger Clinic beginning with this number. The Board of Editors will remain the same and the Bulletin will continue to publish articles on psychiatry, psychosomatic medicine, psychology and related clinical fields. Authors need not be associated with the Foundation in order to submit a manuscript to the Bulletin.

The next number of the Bulletin will deal with Psychiatry in Pediatrics, one of a series of numbers discussing psychiatry as related to various medical specialties. The first of these was the Gynecology and Obstetrics number, January 1943.